Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: MEDME SERVICES CORPORATION P.O. BOX 920173 EL PASO TX 79902	MFDR Tracking #: M4-10-2683-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO REP BOX #: 54	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as stated on the Table of Disputed Services: "MAR for this code is stated as $117.49. Additional payment with interest is due"

Principle Documentation:

1. DWC 60 package
2. Medical Bills
3. EOBs
4. Medical Reports
5. Total Amount Sought: $70.53

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The Provider submitted billing for rental of a Neurosmuscular Electrical Stimulator to the Carrier in the amount of $150.00. The Carrier reviewed the billing and reimbursed the Provider $46.96 for the single month's rental. The Provider subsequently submitted this Request for Medical Fee Dispute Resolution. The Carrier reviewed the Request for Medical Fee Dispute Resolution, and in reviewing the Request for Medical Fee Dispute Resolution, the Carrier determined additional reimbursement was due for the durable medical equipment. Supplemental reimbursement is being issued in accordance with the Texas Workers' Compensation Act and the adopted Rules of the Division of Workers' Compensation…"

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
07/31/2009	NSMT – W1 and Z1OF - 193	HCPCS Code E0745RR	$70.53	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. These services were denied by the Respondent with reason codes:
   - NSMT-W! – Workers Compensation State Fee Schedule Adjustment. This device is being reimbursed according

to fee schedule/UCR allowance for HCPCS procedure code E0730; TENS, four lead, which is the therapeutic equivalent; and

- Z1OF – 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. After carefully reviewing the resubmitted invoice, additional reimbursement is not justified.

2. This dispute relates to monthly rental of a TENS unit subject to the provisions of 28 Texas Administrative Code, Section 134.203(d).

3. The Requestor was contacted by electronic mail on March 30, 2010. A response to the e-mail has not been received as of April 6, 2010.

4. The Respondent has submitted a financial inquiry payment detail and front and back of the canceled check showing payment in the amount of $70.53 was made with check number 896D 75847546 on 02/23/2010. Therefore, in accordance with Texas Administrative Code, Section 133.307(e)(3)(A) the Division has determined that a dispute no longer exists. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Section 133.307, 134.203
Subchapter G, Chapter 2001, Texas Government Code

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 additional reimbursement.

DECISION:

		April 7, 2010
Authorized Signature	Auditor III Medical Fee Dispute Resolution	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.